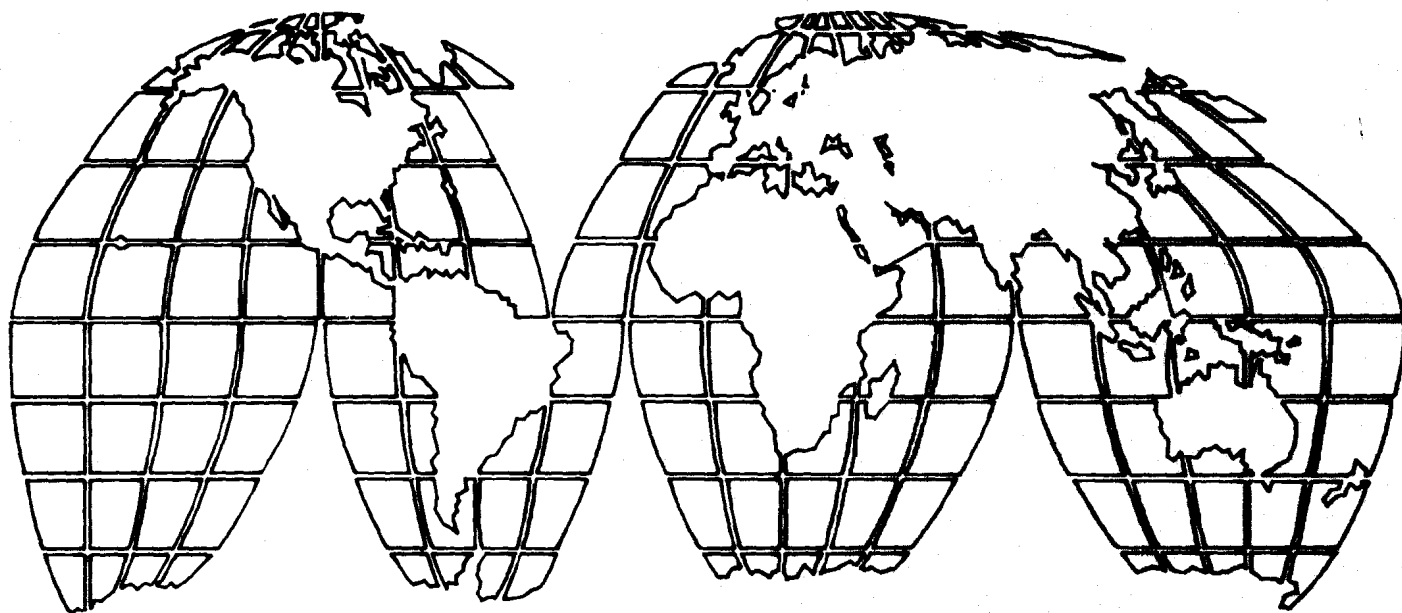


A.I.D. Program Evaluation Discussion Paper No. 1

Reaching the Rural Poor: Indigenous Health Practitioners are There Already

BEST AVAILABLE



March 1979

Office of Evaluation
Bureau for Program and Policy Coordination
Agency for International Development

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REACHING THE RURAL POOR:
INDIGENOUS HEALTH PRACTITIONERS ARE THERE ALREADY

by
Barbara L.K. Pillsbury

A.I.D. Program Evaluation
Discussion Paper No. One

The Studies Division
Office of Evaluation
Bureau for Program and Policy Coordination
U.S. Agency for International Development
March 1979

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PREFACE

Background Note on the Office of Evaluation and Its Discussion Paper Series

The primary objective of the Agency of International Development's Office of Evaluation is to provide AID management with usable analyses of the intended and unintended impact of aided projects, programs, policies, and procedures. It is our intent that lessons gleaned from AID's past inform present planning.

The Office tailors its approach to suit the nature of a problem, its urgency, and the type of data available. After identifying a problem and ascertaining management interest in it, the Office's staff normally links up with or establishes a network of AID and non-AID experts. The staff also reviews information from the Agency's automated data base systems and assembles documents including project papers, project evaluations, and special studies sponsored by other parts of the Agency. In conjunction with this the Office commissions discussion papers by experts who are familiar with the past efforts of development agencies as well as with the problem. It may also hold workshops and conferences and, if necessary, carry out field studies of past projects and programs. The Office does not sponsor basic research on development but concentrates on analyzing available information.

Findings are issued in discussion papers, workshop and conference reports, circular airgrams, action memoranda, sector and subsector studies, and case studies. They are intended to stimulate discussion and innovation and to encourage experimentation. They do not constitute formal guidance unless they are explicitly cleared and issued as such.

The purpose of the series of discussion papers prepared for the Office is to stimulate thought and dialogue on a problem by exploring past experience from new perspectives. Consequently, we have encouraged authors to be constructively critical, to examine explicit and implicit assumptions that are usually taken as given, to look for unrecognized and often cross-sectoral linkages, to examine host-country institutional factors, to examine the way AID's organization, staffing, and procedures affect our effectiveness, and to identify for further examination alternative approaches and policy options.

Because the discussion papers are exploratory they are not intended to be comprehensive in coverage, conclusive in their argument, or primarily technical in orientation. They are intended to help

formulate additional hypotheses for testing and to assess what additional work needs to be done on the problem. We hope that the discussion papers will help stimulate innovative and more effective programming and project design in our overseas missions. The papers also will be of interest to scholars carrying out research on development.

Most importantly, however, we hope that the papers will elicit responses from our readers--responses that will confirm or refute assertions, refine or add issues to be analyzed, and suggest case studies necessary to resolve issues.

About the Author

Barbara L.K. Pillsbury is a medical anthropologist who has conducted original research in Taiwan, the People's Republic of China, and Egypt and has studied widely about the multiple health systems of Asia and the Middle East. She is author of Traditional Health Care in the Near East: Indigenous Health Practices and Practitioners in Egypt, Afghanistan, Jordan, Syria, Tunisia, Morocco, and Yemen which was prepared under contract with AID's Near East Bureau in 1978. Dr. Pillsbury received a PhD in anthropology from Columbia University in 1973 and is presently on leave to the Office's Studies Division from San Diego State University where she is a tenured Associate Professor.

Acknowledgements

The author is grateful to Mr. Robert Berg, Director of AID's Office of Evaluation, for encouraging this study and for his generous support and suggestions during its execution. She is also appreciative for the cooperation provided in her work on this subject by Dr. R.H. Bannerman, Programme Manager of the World Health Organization's Programme in Traditional Medicine. Thanks are due too to Ms. Rita Chacosky of AID for her careful typing of the final manuscript.

SUMMARY

Health and nutritional status is usually poorest and population growth generally most rapid in the rural areas of the developing countries. Yet these are the most difficult areas for national governments and foreign donors to reach; in most developing countries the official health system still serves only a fraction of the population. Not only are there few physicians, nurses, and auxiliary workers in the rural areas. Even when government-sponsored services are available, large portions of the rural population do not seek them out.

percent of all infants in those countries. Indigenous practitioners are sought for treatment of a wide variety of physical and mental illnesses and for advice and services relating to diet and to conception and contraception. Experiences of other donors and of countries such as China generally indicate that the most effective strategy is to discourage only those indigenous practices that are clearly negative, to do little regarding those that appear neutral, and to encourage and build interventions on those that are beneficial.

It is recommended that it be AID policy to encourage greater understanding of community health systems and traditional medicine at all levels of the formal system and to support, where politically appropriate, upgrading and utilization of indigenous practitioners as members of primary health care teams. The World Health Organization has adopted and significantly elaborated this policy and it has been adopted also by many AID-assisted developing countries.

AID has at present at least 17 ongoing or planned projects that utilize traditional birth attendants and at least five that may be utilizing traditional healers. AID documentation systems contain little information about modes of indigenous practitioner utilization or lessons learned thereby. Nevertheless, on the basis of careful consideration of other available information, points of guidance are recommended in this paper regarding traditional medicine and indigenous practitioners.

Discussions with present and former Agency health experts, consultants, contractors, and field project officers, as well as scattered articles and essays by such individuals, indicate a substantial reservoir of valuable experiences concerning interaction between the indigenous and the formal health systems that could be profitably mined for more definitive program guidance and project development. It is recommended that this be done through a series of interviews in AID/Washington, a workshop, and comparative cross-national field evaluations.

We cannot solve our problems by merely relying on the doctors of the new school. Of course the doctors of the new school are superior to those of the old school; but if they do not concern themselves about the sufferings of the people...and unite with the thousands of doctors of the old school in the border regions in order to help make some improvement, then they will actually be showing indifference to the high mortality rate.... Our task is to unite with all the intellectuals, artists, and doctors who come from the old society but are useful, and to help educate and remold them. In order to remold them we must first unite with them. They will welcome our help only if we act properly.

--Mao Tse-tung, 1944*

Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have standing in many places, exerting considerable influence on local health practices. With the support of the health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worth while exploring the possibilities of engaging them in primary care and of training them accordingly.

--Alma-Ata International Conference
on Primary Health Care, 1978**

INTRODUCTION

The Problem

Health and nutritional status is usually poorest and rates of population growth generally greatest in the rural areas of the developing countries. Yet, in terms of health and family planning services, these are the most difficult areas for national governments and foreign donors to reach. In most developing countries today in fact, official health services reach only a fraction of the population. Furthermore, the past decade has brought growing recognition that this pattern is likely to persist into the foreseeable future, regardless of incremental expansion of modern facilities and professional staffs and despite a massive burden of illness.¹

*Selected Works of Mao Tse-tung, 1956:226.

**World Health Organization 1978b:63.

¹See Bryant 1969:49-53, Djukanovic and Mach 1975, and Good 1977:705.

The reasons for this plight are becoming well-known among international health specialists.¹ Not only are there few physicians, nurses, and auxiliary health workers in the rural areas; in many developing countries those health professionals who are deployed to the countryside remain in the rural towns leaving vast numbers of village-resident populations still unserved by either public or private providers of "Western" or "international" medicine.² Furthermore, even when government-sponsored Western-type health facilities do exist in rural areas, large portions of the rural population do not go to them.

One major reason is that many rural people misunderstand and even mistrust Western medicine and its practitioners. Often they find the urban-trained doctors and nurses too socially, culturally, and economically distant from themselves and consequently, aloof, condescending, disrespectful, and unsympathetic to the fact that in rural areas ill health is but one aspect of the intertwined problems of poverty.³ This phenomenon, often called "cultural distance," appears where the organization, practitioners, and procedures of "modern medicine" are at variance with customary beliefs (including concepts of disease), values, symbols of communication, and behavior patterns of the local populations.⁴ In other words, even where modern health services are physically

¹They are also reasons that many health specialists are recently challenging the biomedical model and calling for new models (biopsychosocial, psychosocial, ethnomedical, and so on) to guide the provision of health care assistance in both the developed and developing countries. See, for example, Fabrega (1975), Engel (1977), Kleinman (1978b), and Ahmed and Fraser (1979).

²In urban areas of developing countries of Africa, Asia, and Latin America the physician-patient ratio is one to 2,600; in rural areas it is only one to 47,000. (The United States ratio, in contrast, is about one to 600.) See Susan Cole-King (1978:7).

Many developing country health professionals consider "Western" an undesirable ethnocentric designation for what they believe--and with some justification should be more appropriately referred to as "international" medicine.

³This is illustrated, for example, in Creighton (1977), Jansen (1973), and dealt with at length in the work of Arthur Kleinman (e.g., 1978a and forthcoming).

⁴"Modern medicine" too is a problematic term since it falsely implies that everything within it is "modern" (and thus presumably desirable) and outside it "old-fashioned" (and thus presumably less desirable). In fact, there is much within "modern scientific medicine" that is neither modern nor scientific, but simply part of the tradition of medical practice that historically evolved in Europe and the United States.

present, social and cultural factors may prevent their use and even doom them to failure.¹

This results in the underutilization and bypassing of rural government-run clinics that is reported with increasing frequency from many developing countries.² This includes many countries where AID has supported the construction of such facilities. The fact that so many rural government health facilities are underutilized is one reason the official systems are so expensive relative to their impacts. Simply constructing more buildings is obviously not the answer.³

¹This is illustrated by a case study from New Guinea where the introduction of rural health programs based on sound medical-technical considerations met with unexpected failure because values relating to the culture of the patients were not considered (Van Amersvoort 1964). See also Good (1977:705). This observation regarding provision of health services suggests a parallel to the opinion in the population planning debate that simply providing the means of contraception will not automatically assure their use.

²"Underutilization" refers in a general sense to the rural facilities not being used to the full extent for which they were planned. "Bypassing" usually designates more specifically rural people ignoring the local facility and going directly to a higher-level government facility (such as emergency rooms of urban hospitals). This usually results also in extreme overcrowding of the latter facilities. Excellent presentations of the problem are an AID-supported study in Thailand (Day and Leoprapai 1977) and studies in Tunisia (Creyghton 1977 and Benyoussef 1974).

Another major and related reason for this underutilization is the short and undependable supply of pharmaceuticals in many rural health units. At the same time, in many developing countries pharmacists (dispensers both of traditional herbal medicines and modern "Western" drugs, depending on the country) conduct a thriving business in the private sector.

Consensus among many participants in AID/Asia Bureau's recent Health, Population, and Nutrition Meeting (Manila, October 29-November 3, 1978) is that foreign donors, as well as health planners of countries being supported, do not yet know enough about the logistics for successfully supplying drugs to rural areas. It was suggested that operations research be conducted on this important problem accepting as a basic working principle the WHO emphasis on regularly supplying only a minimal number of basic drugs rather than irregularly supplying a larger number.

³See Ayad (1978:23) for a persuasive argument that AID, in a Tunisian rural development project, should first improve the health personnel infrastructure before constructing any additional buildings.

Indigenous Health Practitioners: The Primary Health System of the Poor

For reasons such as the above, together with constraints of time and limited financial means, many rural people still turn to traditional remedies and to convenient and culturally familiar indigenous health practitioners who reside in their village. It is estimated that at least 2.3 billion people--more than 55 percent of the entire world population--continue to rely upon indigenous practitioners and healing techniques for treatment of a wide variety of physical and mental illnesses.¹

That rural and urban poor people do resort to traditional therapies and practitioners should not be considered a problem, however--as has been the view among many politicians and promoters of "modern medicine" until only recently. Rather health planners should begin by considering these community-based practitioners as an important potential resource in the improved delivery of health services to the rural poor.

That health planners once regarded a territory unserved by Western medicine as devoid of health care services relates to what has come to be known as the "empty vessel fallacy." In fact, nowhere do people live in a health care vacuum. In all cultures people have always become ill; in no cultures do others stand idly by. Each culture has produced over the centuries its own adaptive methodologies for coping with illness. These embody an indigenous etiology, that is, a system explaining the occurrence of illness and disease based on the world-view and religious beliefs of the particular people in question. It is the underlying explanatory system, in interaction with features of the ecological niche the population inhabits, that dictates local strategies for coping with ill health. These are strategies that international medicine has all too long ignored. As an AID health advisor in Thailand observes:

Thailand's health system suffers from a paradox common to health systems of other Asian developing nations: These are a myriad of problems in health to be addressed and yet the existing government-supported system is underutilized. It is estimated that only 15 percent of the persons requiring or seeking medical care in Thailand go to government-sponsored facilities. An additional 20 percent seek services from health professionals in the private sector; however 50 percent receive services from pharmacists and druggists and 15 percent seek out traditional healers, spiritual advisors, or injectionists.

¹Good 1977:710.

In other words, well over half the people living in Thailand seeking medical services receive care from untrained (in a Western sense) professionals. Perhaps the recipients of service are trying to tell us something.¹

The argument that health planners and policy-makers should give serious attention to the non-formal health sector is not an either/or proposition. Rather it is an argument that the immensity of the task at hand demands development of culturally appropriate strategies and maximization of all available resources--including, and not least of all, those already in the communities. It is an argument also for viewing indigenous health practitioners and practices as important potential contributors in primary health care.

The primary health care approach emphasizes community participation, bridging the gap between the health center and the home, and working "with what is there." It is significant for an international donor such as AID that these principles were articulated and agreed upon by delegates from some 140 countries (including about 100 ministries of health) at the International Conference on Primary Health Care held in Alma-Ata in September 1978, a probably watershed in developing country health care.

Indigenous practitioners are community workers who are already "there." Not only are they already there but they are estimated to still form the basic core of health workers for about 90 percent of the rural populations in the developing countries.²

Reliance upon traditional practitioners should not be dismissed as a wholly rural phenomenon likely to soon disappear under pressure of modernization, however. Indigenous health practitioners also live and work in urban communities. Furthermore, in many countries urbanization and accompanying social change have created new opportunities for a wide variety of practitioners to flourish.³

¹Merrill 1978:1. This is a significant finding for a country so far down the road of "modernization" as Thailand.

²World Health Organization (1975:3).

³This is described for Botswana in an AID-contracted study (Osborne and Balintulo 1978). Urbanization even gives rise to new categories of practitioners and practices as urban poor seek to cope with pressures of social stress and poverty. In Zaire, for example, thousands of traditional and self-styled practitioners are reported to have migrated from the countryside into burgeoning cities such as Kinshasha where they are currently estimated to exceed 10,000 (Good 1977:706). (Continued next page.)

Who Are The Indigenous Practitioners?

Indigenous health practitioners both live and work in the rural communities; many are only part-time health workers and, like other members of their communities, are essentially farmers, artisans, teachers, or small-scale entrepreneurs. Indigenous practitioners are best understood in the context of the community health system. By "community health system" is meant here all beliefs, behaviors, practitioners, and interventions within a given community that have intended or unintended consequences upon the health of its members.¹

Beliefs refers to indigenous etiology--the locally prevailing explanations of what causes and cures illness and related misfortune. Behavior includes deliberate health-seeking behavior, other practices that have intended or unintended positive or negative impacts upon health status, and interpersonal and other social relationships that influence both health status and treatment outcomes.² Practitioners in low-income communities of developing countries include indigenous healers and midwives, pharmacists and other dispensers of both herbal and modern medicines, private practitioners of Western medicine, and government health workers. Interventions include specific measures to improve health but also programs and actions taken in other areas that influence health status. Health interventions may be distinguished as occurring within the context of three systems to which community members often resort simultaneously. These are the traditional/indigenous system(s), the international system, and the lay system

(Cont.) Instructive lessons can also be drawn from the report of a UNFPA project evaluation team that investigated the issue in a Philippine provincial city. There the local public health director has argued for many years that, because the city has so many modern facilities, women should not have to use traditional birth attendants and thus that the latter should be ignored rather than trained in aseptic procedure. Nevertheless, about 42 percent of deliveries are still being attended by the traditional birth attendants (Williamson, Osborn, and Cahiles 1977); see also Rubel, Liu, Trostdal, and Pato (1971). Press (1978) provides a functional overview on urban folk medicine.

¹An excellent handbook for identifying, assessing, and understanding the importance of the multiple parts of a community health system, and how it fits into the community in general, is Ann Brownlee's 1978 Community, Culture and Care: A Cross-Cultural Guide for Health Workers. Insightful perspectives from Asia, including informative case studies from Indonesia, Malaysia, Philippines, India, and Nepal, are presented in a 149-page report titled Community Health in Asia (Rifkin 1977).

²Non-western disease etiologies are described and analyzed in Foster (1976).

(advice and interventions by such people as family members, neighbors, and older "wise women").¹

It is useful to note at this point that "indigenous" and "traditional" are used more or less synonymously throughout this paper, as indeed they are in most of the literature on this subject. Defined more narrowly, however, "traditional"--in the context of developing-country health care--refers to phenomena that originated prior to contact with the Western system. Thus, traditional medicine is defined as:

...the sum total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention, and elimination of physical, mental, or social imbalance and relying exclusively on practical experience and observation handed down from generation, whether verbally or in writing.²

"Indigenous," in contrast, refers in its narrower definition to a practitioner or practice deriving from and existing within a unit of reference, whether of ancient or relatively recent origin. A third and related term, "folk," usually designates traditional/indigenous practices or practitioners that exist outside the context of formal institutional transmission of knowledge.³ Indigenous practitioners may be divided into two major categories: healers and midwives.

An indigenous healer may be defined as:

...a person who is recognized by the community in which he or she lives as competent to provide health care by using vegetable, animal, and mineral substances and certain other methods based on the social, cultural, and religious background as well as on the knowledge, attitudes, and beliefs that are prevalent in the

¹An insightful description of the lay system and its relationship to the indigenous and international systems is presented in Brownlee (1978).

²World Health Organization (1978:8-9).

³Thus, the lay system includes many "folk" remedies, and an example of a "folk" practitioner would be an illiterate bone-setter in a remote village who has acquired skills only through practical experience. In contrast, practitioners of traditional Chinese or Indian Ayurvedic medicine, both of whom have received training from specialized institutions, could not be classified as folk practitioners.

community regarding physical, mental, and social well-being and causation of disease and disability.¹

Indigenous healers include traditional physicians, herbalists, pharmacists, bonesetters, folk ophthalmologists, folk psychiatrists, snake and scorpion bite experts, and other specialists. They provide individual preventive and curative services for a variety of conditions such as arthritis, diabetes mellitus, hypertension, paralysis, psychiatric ailments, and functional disorders. People often turn to them in times of illness and upon their advice frequently depends further action regarding treatment or resort to another type of practitioner. Indigenous healers also function as counselors for marital and other domestic problems and may be consulted over natural disasters such as famine, drought, floods, and epidemics.

Village midwives (traditional birth attendants or "TBAs") deliver some 60 to 90 percent of all infants in certain developing countries and about two-thirds of all babies in the world.² Often they provide prenatal and postnatal care, assume responsibilities for household duties during the postnatal period, and give advice on sexual behavior, conception and contraception, diet, and minor health problems.

It may be said that most indigenous practitioners perform on a sliding-scale, fee-for-service basis. In the local languages and thus from the community perspective, however, these practitioners are given "gifts" for their "help." Such "gifts," which may be in cash or kind, usually vary in amount, within a locally prevailing range, according to the "helped" person's household wealth and are waived for the most indigent. Many indigenous practitioners, and perhaps the majority of indigenous practitioners in some countries, are motivated not by the desire for material reward or employment per se but by altruism and the desire to provide services and alleviate discomfort for those who seek them out.³

Having described what is the predominant means of health care for the majority of the rural poor, the challenge for AID and developing-country health planners is to find means of effectively using and building on this resource. Before discussing possible courses of action, however, it is useful to review AID's experience in indigenous health practitioner activities.

¹World Health Organization (1978:8-9).

²World Health Organization (1978:22).

³See, for example, Williamson, Osborn, and Cahilles (1977).

AID ACTIVITY: HOW IS AID INVOLVED AND WHAT HAS IT LEARNED?

How Is Aid Involved?

The Agency has been involved with traditional health care in numerous ways. Up to this point, however, it has not aggregated much knowledge on the subject in any way such that it can be drawn upon either by decision-makers in Washington or project officers in the field. Few AID health officers appear to claim any comprehensive overview of what the Agency is or has been doing in this area. AID's Office of Development Information and Utilization (DIU) is only beginning to turn up a portion of the projects that have some traditional health care component. No AID reference holdings appear to have begun collecting the numerous documents related to traditional health care that have been produced by various parts and consultants of the Agency. Information presented in this paper has been brought together through inquiries conducted throughout AID's Washington offices. This initially reaped only a meager harvest but eventually over the course of a year and a half brought many additions as documents came to the attention of alerted colleagues.

AID's Office of Health has identified 45 ongoing and planned projects that it describes as supporting the development of integrated low-cost health, family planning, and nutrition delivery systems.¹ Of these it appears that at least 18 are utilizing, or plan to utilize, traditional birth attendants, and at least seven may be utilizing traditional healers. Of the programs utilizing traditional birth attendants, nine are in Latin America (Brazil, Colombia, Costa Rica, El Salvador, Guatemala, Haiti Honduras, and Nicaragua), eight are in Africa (Cape Verde Islands, Central African Empire, Ghana, Liberia, Mali, Niger and Tanzania), one is in Asia (Thailand), and one is in the Near East (Afghanistan).

Of the programs that appear to draw upon indigenous healers, three are in Africa (Central African Empire, Kenya, and Niger), three are in Latin American (Bolivia, Brazil, and Haiti), and one is in Asia (Thailand).²

¹There are an additional 200 or so health or family planning or nutrition programs that AID supports which do not come under the designation "integrated." The number of these that utilize traditional practitioners has not yet been determined nor has information from them on this subject been synthesized.

²This information has been culled from computerized DIU summaries and from summaries of AID Project Identification Documents and Project Papers that are presented in a survey by the HEW Office of International Health (O.I.H. 1978, Vol. 1). Unfortunately, (cont.)

The Honduras project illustrates ways in which AID-supported programs utilize traditional birth attendants.

The rural health centers will be staffed by one salaried MOH auxiliary nurse, one volunteer community health worker, and one volunteer empirical midwife (traditional birth attendant) The empirical midwife will be involved in visiting expectant mothers on a prenatal and postpartum basis in addition to providing childbirth assistance. The midwife will work together with the auxiliary nurse and community health workers in demonstrating food handling and preparation techniques; these workers will be capable of providing nutrition education for pregnant women and other nutrition services. Only the midwife receives training in breastfeeding instruction. The midwife also counsels women in family planning and child-spacing and conducts follow-up visits to women in family planning programs. Depending on results from an experiment in the urban areas being conducted by the Honduran Family Planning Association, the community health workers and empirical midwives will sell contraceptives and receive a sales commission.¹

Other AID experiences with indigenous health care include at least the following:

- (1) Conference sponsorship (e.g., "Tradition, Behavior, and Health;" see Agency for International Development, 1975);
- (2) Social soundness analyses done as part of project planning (e.g., Philippine PUSH [Panay United Services for Health] Project; Cairo Urban Health project--see Sukkary; Pakistan Basic Health Services--see Plunkett);
- (3) Surveys of literature and other donors' experiences (e.g., Pillsbury 1978);

(Cont.) the language used in these summaries is not always sufficiently precise for the reader to determine whether the project is using a traditional birth attendant as opposed to some other category of indigenous practitioner, or whether "indigenous health workers" means traditional practitioners or simply persons indigenous to a community who are selected to become community health workers. This is a general problem that calls for greater terminological refinement to make the Agency information systems more dependable and useful. This is also a problem with regard to the present investigation in that a more accurate overview will necessitate actually amassing and reading through all the project documents. Even then it is not possible to be sure that projects have not been missed.

¹Honduras Integrated Rural Health/Family Planning Services Project Paper (522-0130).

- (4) Sociocultural portions of health sector analyses (e.g., for El Salvador, see Harrison; for Tunisia, see Ayad; for Egypt, see El-Zein);
- (5) Field research (e.g., Neumann and Bhatia, Osborne and Balintulo, Jett);
- (6) Inclusion in Country Development Strategy Statement of concern for utilizing traditional practitioners (AID 1979:50);
and
- (7) A technical manual (Office of International Health 1979).

The Need for Evaluation

What AID has learned from all this involvement is uncertain. There is thus need for two kinds of follow-up. One is simply to assemble at some specific place within the Agency a repository of Agency documents concerning traditional health care and practitioners. Ideally this would also include the World Health Organization materials, documents from other donors, and certain published materials. This should be accessible through the Office of Development Information and Utilization.

A second step is evaluation. This could begin in Washington with examination of the collected documentation from Agency involvement described above. Field evaluation would seek to answer two types of questions. First, what is the efficacy of the therapies employed by traditional practitioners? This includes determining not only the pharmacological efficacy of herbs and other substances employed as traditional medicines but also the effectiveness of all other (i.e., the non-pharmacological) aspects of a traditional therapy as well as the overall effectiveness of the given therapy as a whole.¹ This requires local investigation by teams combining medical and social science expertise. Considerable activity has been initiated in many developing countries to assess the properties of traditional medicines--an activity quite readily acceptable to local medical establishments provided testing is done in the familiar laboratory environment. Evaluation of overall effectiveness of traditional healing therapies, however, requires field sensitivities and skills not emphasized in most medical training--with the result that less evaluation activity of this sort has been initiated by the developing countries. A more useful beginning with regard to overall effectiveness lies in the social science literature.²

¹A major reference for evaluation of pharmacological efficacy is Khan (1976).

²Much of this literature is being produced by physicians who also hold degrees in anthropology or other social sciences (e.g., Kleinman 1976 and 1978 and Torrey 1972).

The second question that field evaluation could seek to answer is what has been the experience of the Agency (and of developing-country health establishments and other donors) in collaborating with indigenous practitioners? What has been the nature of the collaboration? How have indigenous practitioners been identified, selected, trained, supervised, and their performance evaluated?¹ How have they facilitated or hindered service delivery? What other problems have arisen? Can traditional midwives be trained to perform as effective family planning motivators and suppliers, or is this "against their interests"?² What other issues regarding indigenous practitioners should be broadly examined to arrive at more effective strategies for improving AID-supported health delivery systems?

¹For examples of this type of evaluation activity see Peng et al. (1974) and Lopez (1974). The position of evaluation in such programs is schematically indicated in the diagram "The Process of Integrating Traditional Birth Attendants into Prevailing Health Care Systems" (World Health Organization 1978:24; see p. 21).

²The latter assertion is frequently heard from urban-oriented planners and health officials. There is considerable evidence, however, that traditional midwives can become effective family planning workers when program planners give them incentive to do so. See, for example, Neumann and Bhatia (1973), who report on an AID-funded study, El-Hamamsy (1973) and Peng et al. (1974).

OBJECTIONS TO INDIGENOUS PRACTITIONERS

While there is considerable involvement already of some donor agencies and certain developing country health ministries in training and utilizing traditional practitioners, one wonders why those activities are not more widespread. The subject of traditional practitioners still frequently produces raised eyebrows, if not outright objection.

Why is this so?

The reasons are manifold. They have to do--as indeed do all medical issues--with a complex intertwining of scientific, historic, and human-nature factors. These linkages and relationships are not always (and perhaps only infrequently) recognized, however.

Issues raised include the following. These are presented here to stimulate discussion on this important subject. This section is not intended to be definitive; each issue in itself merits greater investigation and deliberation.

"Second-class Medicine" for "Second-class Citizens"?

Given the environment of persistent poverty and inadequate resources, why haven't health planners in the developing countries since long ago relied on indigenous practitioners to supplement their efforts, especially for serving the hard-to-reach populations? This question is more complex than it may seem on the surface. In part it is because medicine itself has become so highly specialized a field that many of its professionals, regardless of nationality, develop a trained incapacity to consider the holistic sociocultural context in which health care is sought, stressing instead sophisticated technology and clinical procedure.

Numerous developing country policy-makers and health administrators have sought and continue to seek international donor support for sophisticated facilities and equipment. "Why should only the rich countries be entitled to high technology medicine?" some assert. "Does not your attempt to give us second-class medicine in fact reveal your true view of us?" In this context, "second-class medicine" designates generally any low-cost basic services plan, including but by no means exclusive to those incorporating indigenous practitioners.

This inclination to regard low-cost basic services, including services provided by indigenous practitioners, as "second-class medicine" is an unfortunate part of the colonial legacy. Western medicine came with colonization to Asia, Africa, and Latin America

to serve the European and American colonizers and entrepreneurs. Eventually it became available to the colonized urban elites and, where medical missionaries penetrated, to a few select rural populations as well. In admiration for and imitation of Western ways, Westernizing local elites turned their backs on much of their own cultures, including their healing traditions. Many of the Western administrators joined these elites in disparaging the local traditional medicine as backward and superstitious.

In many colonies and newly-independent nations--influenced by the Euroamerican medical establishments--laws and regulations were passed making indigenous practitioners, including traditional birth attendants, "illegal." This was done in the belief that such legislation would force the indigenous practitioners out of practice and existence. Most health projects of international donors had little to do during this period with indigenous practitioners. Rather, this was the period when donors (including AID) concentrated on physician training and construction of hospitals and other urban facilities in the belief that eventually the benefits thereof would trickle down to the rural populations as well.

In most countries time has shown legislation against indigenous practitioners--like the trickle-down strategy--to be unrealistic. This is especially true in rural areas where the governments responsible for such legislation have not succeeded in introducing acceptable alternative services. In Tunisia, for example, despite legislation against traditional practitioners in 1958, as recently as 1969 some 1,400 qablas (traditional birth attendants) were still reported to be performing over 70 percent of the country's deliveries.¹ Afghan traditional birth attendants are reported confused and perplexed by the implication that traditional birth attendants might be considered illegal. "What do laws have to do with us"? they are said to have responded. "Laws are for men in cities. We receive our power from God."² Evidence from numerous other countries also indicates that where legislation has been passed against indigenous practitioners it does not appear to succeed in causing them to cease practice so long as there is popular demand for their services. Health planners and modern sector providers would do well to better understand the nature of this demand and from it take cues for making their services more acceptable.

Many Westerners have assumed that developing country health officials know and understand all about the healing systems

¹IBRD figures cited in Thorne and Montague (1977).

²Anthropologist Pamela Hunte, personal communication. See also the Afghan Family Guidance Research Reports by Hunte and Anne Macey (cited in Pillsbury, 1978).

indigenous to the populations for whose health they are responsible. In fact this cannot be assumed and is not always true--in part an unfortunate consequence of the colonial legacy described above. In many cases inherited prejudice on the part of health planners against traditional agrarian-based aspects of their own culture has precluded knowledge or any consideration of the possible efficacy of indigenous therapies.

A different and more recent trend among other developing-country policy-makers and health care providers is in part a reaction against the earlier attempt to imitate the West and the consequent sense of "second-class citizenship" that this created in many. This recent trend, part of the general reassertion in the developing countries of national pride and identity, is to emphasize local healing traditions as part of the nation's cultural heritage. For example, the eminent Nigerian psychiatrist (and now WHO Deputy Director-General), Dr. Thomas Lambo, has urged his countrymen and other developing country health planners that they "not imitate but innovate"--that they creatively combine the best of both the indigenous and the imported systems.¹ In China "traditional and Western medicine combined" has been made one of the four basic principles of national health policy, a policy that has recently had great influence in the developing and more developed countries alike.

The view of basic (low-technology) health services as "second class" may also be giving way because of the dissatisfaction increasingly expressed in the more developed countries over technology-centered medicine and the consequent movements in these countries toward more humanistic health care. The fact is increasingly recognized that, even in countries with highly sophisticated medical technology, many people often turn to community outreach and alternative non-establishment health providers and advisors to meet psychological, social, and also organic needs that remain unsatisfied by physicians and the associated orthodox care services.²

Quality of Care: Aren't Indigenous Practitioners Dangerous?

Western physicians who have practiced in developing countries occasionally present graphic accounts of cases grossly bungled by one or another indigenous practitioner. Often these are presented as if constituting de facto evidence against working with traditional

¹Lambo (1973).

²The fact that the rural health system remains woefully inadequate even in such supposedly medically advanced countries as the United States may also be an influential factor.

practitioners but without any discussion as to whether or not alternative forms of care had been available or as to socio-economic factors that might have contributed to the unfortunate outcome.

Yet within every health care specialization are practitioners who are incompetent or occasionally careless, who make inaccurate diagnoses, who prescribe inappropriate therapies or who ineptly implement appropriate therapies, who fail to make proper referrals or to make them in timely fashion, and at whose hands patients even die as a consequence. This is well recognized in the West where cases of malpractice and iatrogenic complications are increasingly giving rise to greater concern.

If some indigenous practitioners are incompetent and others occasionally careless, then they are not alone. Westerners do not reject all doctors, nurses, and anaesthesiologists because of the inadequacy of a few. For health planners to categorically dismiss all indigenous health practitioners on the grounds "they are dangerous" is comparably simplistic and shortsighted.

"But the two situations aren't comparable," some may protest. Of course they are not. What is needed, however, is a closer look at how they differ and the realization that where the two systems differ they may in fact be complementary.

A significant difference, as regards the quality of care issue, is that for most indigenous practitioners there is no formal system of regulation or licensure which health planners and administrators can utilize in distinguishing competent from incompetent practitioners. Formal regulation is seldom part of village culture, although each community generally shares a common set of criteria by which practitioner performance is informally evaluated. This appears to include in most cases four essential users' criteria that have been advanced to explain the persistence of traditional medicine in general. These are accessibility, availability, acceptability, and dependability.¹

Citing these four criteria does not mean that all traditional practitioners and therapies are accessible, available, acceptable, and dependable all of the time. But they must be sufficiently so or millions of people--including also many to whom "modern" medicine and even costly private care is available--would not seek them out. Patients resort to practitioners, whether African medicine man or Western cancer specialist, only when experience has shown that practitioner likely to effect a cure or bring relief. In both cases, even when disability or death results, the patient and those

¹Inchinda 1976:133.

close to the patient take comfort in having "done everything possible" given constraints of resources and knowledge.¹

Closer examination of the dangerousness ascribed to indigenous practitioners reveals at least four different situations, each of which should be approached differently.

First, as indicated above, some individual practitioners may be relatively incompetent while most in the same specialization are basically competent.

Second, an indigenous specialization may itself be based or concentrated on a potentially dangerous practice--such as bleeding or cauterization--that is commonly sought by large proportions of a population. So long as there is widespread belief in the efficacy of the practice, however, legislation is not likely to bring it to any quick halt without a concerted health education campaign clearly based on thorough understanding of why the practice is resorted to in the first place.²

Third, an indigenous specialization may be necessary and desirable and the individual practitioner fundamentally competent, yet performance of traditional duties may include unsafe but quite easily modified practices. An example is the application by traditional birth attendants in South Asia of cow dung ash to the umbilical stump, a procedure contributing to neonatal tetanus. Governments that have sought to legislate indigenous practitioners out of existence have in general neither accomplished this goal nor contributed significantly to improved health status through elimination of unsafe practices.

Other governments, in contrast, have developed strategies for identifying, upgrading (training), and supervising or otherwise regulating indigenous practitioners--especially traditional birth attendants. In general this strategy has not succeeded in rounding up and placing under supervision all traditional midwives in the country. Nor should it have been expected to, for it takes more than laws and regulations to bring about compliance by thousands of individuals in widely dispersed villages. But the strategy has

¹A more effective articulation of this phenomenon is presented in Newman (1962) and Torrey (1972).

²An example is bleeding in Tunisian (incisions made on the forehead, neck, or earlobes) which, according to popular interpretation of the humoral theory, is necessary for expelling "bad blood." Although illegal and punishable by a small fine, the practice is still commonly performed by local barbers and by women at home (Hermanson Klein 1976:86, 167-168).

succeeded in winning the cooperation of large numbers of traditional midwives and, where it has done so, in lowering infant mortality rates.¹

Fourth, an indigenous specialization may be necessary and desirable and the individual practitioner fundamentally competent, yet he or she may perform procedures that are often dangerous and not easily curtailed. Examples are twig-induced abortion and "female circumcision" (clitridectomy and infibulation), which some traditional midwives frequently perform.

Such procedures are commonly sought by large numbers of people (in this case women) because they want and believe they need the results. Frequently they turn to one of the community's traditional midwives. Health administrators should not make her the scapegoat for what is a much larger problem, however, when in fact the same procedure is often performed--only more safely--by modern-sector specialists.² Abortion, for example, is but one means to prevent an unwanted birth. It is not the traditional midwife who does not want the birth but the pregnant woman. The problem must be seen in broader perspective. A woman who seeks an abortion from a traditional midwife might alternatively or in absence of the midwife resort to a more dangerous self-induced abortion or to a safer yet perhaps illegal physician-induced abortion. The appropriate focus here should be not on condemnation of the midwife but on provision and promotion of more effective means of family planning.

What the above discussion calls for is the need to carefully evaluate locally-prevailing health practices--to classify into one category practices that appear beneficial, into another those that are clearly detrimental, and into a third those that seem neutral. It appears most pragmatically sensible to attempt to change only those practices that are clearly injurious.³ This is both as part of indigenous practitioners' training programs and as part of health education for the general populace.

"Quality of care" should be understood in the broad sense and evaluated, in large part at least, by patient satisfaction. Quality of care is not just sophistication of technology and medical intervention. It is also quality of caring. Villagers judge indigenous and modern practitioner alike by this standard.

¹Verdere and Turnbull (1975).

²For discussion of the epidemiology and physical and psychological dangers of female genital mutilation ("female circumcision") see Cook (1977), Baasher (1977), and Hosken (1978).

³See, for example, Taylor (1975).

Competition or Collaboration?

Are practitioners of international medicine "in competition" with indigenous practitioners? Is the international system itself in competition with various local systems? Will one side eventually win out or will there be a pluralistic co-existence of separate systems within a given country and even within a community? Or will there be integration of international and indigenous systems? Will there be integration of international and indigenous practices within the healing repertoire of a single practitioner? Should there be? If so, how? These are questions that have preoccupied many investigators and been the subject of innumerable conferences.¹ There is no simple answer.

Earlier, to explain why people in developing countries rejected Western medicine, a so-called "adversary" model was postulated. Western and indigenous healing systems were viewed as battling for the allegiance of the given community. It was hypothesized that traditional-minded people divide ill-health into two categories: first, diseases that Western-type physicians understand and can cure; and, second, illnesses that those physicians do not know about, much less understand, and that they therefore cannot cure. Acute, infectious diseases yielding to antibiotics were put into the first category in which the superiority of international medicine is easily demonstrated. Chronic illnesses, disorders with major psychological components, and culture-bound syndromes (such as the Latin susto, the Chinese koro, and afflictions caused by the evil eye in the Near East and South Asia) would remain, it was postulated, the domain of the indigenous healer.

While there is considerable data to support this dichotomous model--diseases Western-type physicians can cure and illnesses they cannot--time has shown it to be overly simplistic.² Some people in developing countries may seek treatment according to this distinction during the initial period of contact with the international system. Nevertheless, evidence now shows that where they have had access to Western medicine of reasonably good quality for a generation or so, then this international system generally wins their primary loyalties. Where quality care has not been available, then populations still place primary faith in indigenous healing methods. In either case, where both systems co-exist resort is often eclectic. That is, people seek out both modern-sector type and indigenous practitioners for different problems, for the same problem at different stages in the

¹For example, the Wenner-Gren Foundation's Burg-Wurtenstein Symposium on Asian Medical Systems (see Leslie 1975).

²See Foster (1975:6-7), Kunstadter (1975), and Warren (1974). Related to this, it cannot be categorically asserted that traditional practitioners oppose learning and using modern science-based methods and equipment. Many are eager to do so. (See, for example, Conco 1972 and especially Landy 1974.) Results vary from context to context.

hierarchy of resort, or even simultaneously for a problem considered serious.¹

The accumulated evidence thus indicates on the one hand the ultimate eventual primacy of Western medicine where services are of reasonably high quality over a lengthy number of years. On the other hand evidence also indicates that such a transition to a state of widespread, easily accessible, high quality Western-type health care will be far more difficult and costly than previously anticipated.

In the meantime there is probably no developing country where the health of the rural and low-income urban population would not be benefitted by cooperation of some sort between the official and the indigenous practitioners.²

While results differ for many reasons (including, for example, the colonial experience of the country concerned), formal recognition and training to upgrade indigenous healers seems potentially promising in three areas in particular.

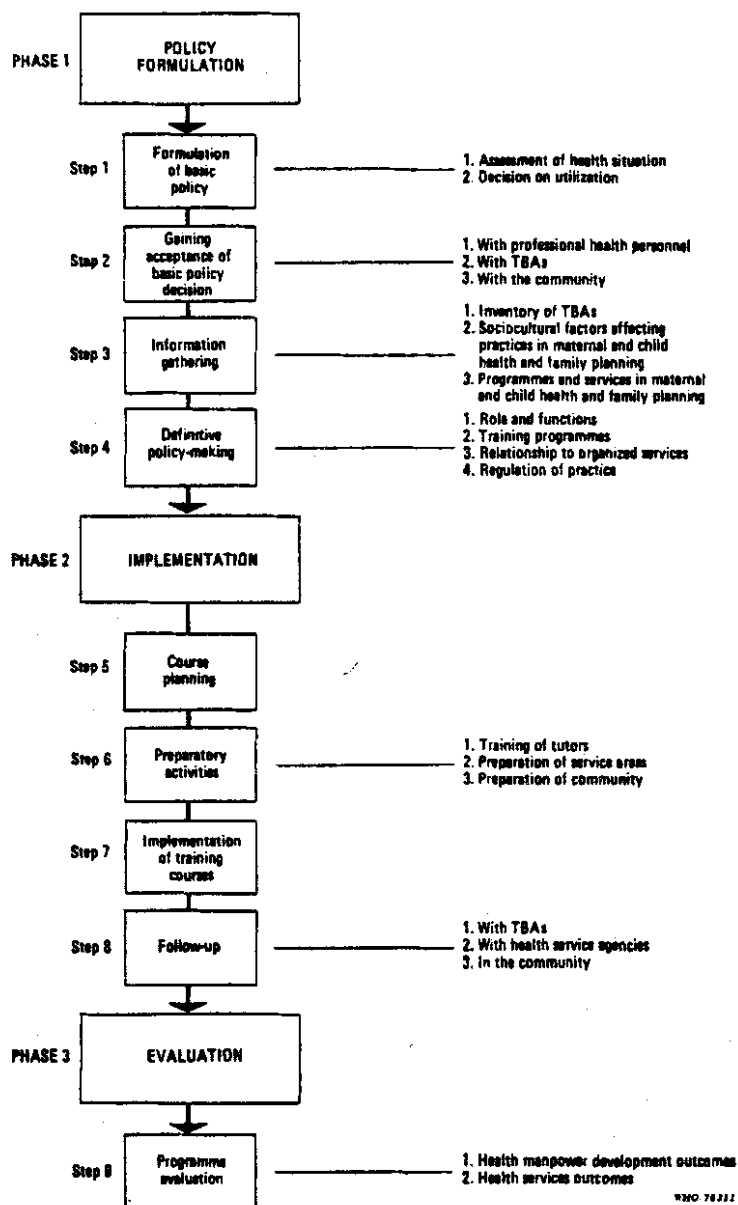
First, there have already been numerous successes in the incorporation of traditional birth attendants into formal health systems and a detailed guide to their training and utilization is now available.³ (See the diagram on page 21 "The Process of Integrating Traditional Birth Attendants into Prevailing Health Care Systems.")

¹A useful discussion of patterns of resort in relationship to health planning is found in Nichter (1978). Health planners should expect that the intended beneficiaries of their programs will probably engage in such eclectic health-seeking behavior; in most low-income populations it is more likely to be normative than abnormal. In fact, this is a universal phenomenon which, while differing in degree, is observable throughout the U.S. as well--and not just in poor and ethnic communities.

²An increasing number of persons with developing country expertise argue this emphatically. See, for example, Ademuwagun (1969 and 1974), Ahmed and Kolker (1979), Basuki et al. (1975), Bhatia et al. (1975), Imperato (1975), Messing (1972), Osborne and Balintulo (1978), and the WHO materials cited elsewhere in this paper.

³See, for example, case studies from Tanzania (Dunlop 1974-75), Liberia (Dennis 1974-75), Guatemala (Cosminsky 1977), India (Neumann and Bhatia 1973), Bangladesh (Chowdhury 1978), and elsewhere in Asia (Peng 1974).

The Process of Integrating Traditional Birth Attendants into Prevailing Health Care Systems



Second is the area of mental illness, in which it appears that indigenous healers have at least about the same therapeutic success that Western psychiatrists do, and in any case therapies that are more culturally appropriate. Because patient expectation is so important to healing, it seems reasonable to expect that in the absence of organic dysfunction, mental stress and illness can be alleviated by indigenous curers who have demonstrated successful healing methods in the past.¹

A third area is the indigenous use of local herbs--something which may be the domain of an indigenous specialist or general knowledge shared by experienced laypersons in the community.²

Where indigenous health practitioners have been brought into direct collaboration with the rural health team their practices should be observed and--as appropriate to improved health care delivery by all members of the team--not only modified, upgraded, or eliminated, but also learned from. One example concerns the hilots (traditional birth attendants) of the Philippines, who attend over 40 percent of that country's births. Since 1954 the Philippine Ministry of Health has been conducting hilot identification and training and now maintains a registry of over 30,000 hilots. Hilot training includes modification of the cord-cutting procedure, for instance, by substituting stainless steel scissors for the traditional bamboo razor.³ Collaboration with the hilots has, on the other hand, taught some of the "modern" midwives that to be more effective in bringing health care to the rural poor they must be willing to provide some of the services, such as massage and food preparation, that villagers expect and receive from the hilots.

¹See Maclean (1971), Prince (1964), Lambo (1973), and Warren (1974) for discussion of successful indigenous treatment of mental illness in West Africa. See also Basher (1976), Harding (1977), Kleinman (1976 and 1978), Lo (1976), Singer et al. (1976), and Torrey (1973).

²Edgerton (1971) presents an insightful discussion of a considerably debated issue, namely whether the effectiveness of African "spiritual" healers is primarily due to their manipulation of symbols and patients' beliefs and expectations or to the efficacy of herbal therapies that are part of the treatment they administer. Evidence exists for both positions. See Brownlee for discussion of the "lay health system" and why planners need to understand it for more effective provision of community health services. Many herbal "home remedies" are an important part of this system as well as being administered by specialists.

³See Mangay-Angara (1977) as well as numerous publications regarding the hilot program available through the Ministry of Health's Maternal and Child Health Division which Dra. Angara heads.

To Eliminate or Build upon Indigenous Health Practices?

Even where formal collaboration with indigenous practitioners is not possible or practical, it is advantageous to relate formally-provided health services to indigenous practices and the concepts that underlie them. This issue has been commented on above but deserves further elaboration.

As already indicated, any locale or system's health practices may be viewed along a positive-negative effectiveness continuum. At the one extreme are apparently negative practices such as the cauterization performed by many rural and even some urban poor throughout the Near East. Along the middle range of the continuum are practices (such as incantations and many other magico-religious practices) which may appear irrelevant to restoring health yet have important psycho-therapeutic value and effectiveness in relieving some conditions--mild neuroses, for example. Other (and some of those same) mid-range practices, however, may be of no consequence one way or the other for other conditions, such as infectious diseases. Finally at the opposite end of the continuum are therapies, such as the use of certain herbs and foods, that are of clearly proven effectiveness.

Few people with in-depth experience providing health care to rural communities would argue for categorical elimination of all indigenous practices. Rather, a prevailing consensus is indicated that points to passing judgment on a practice-by-practice basis. In any case, building upon knowledge about locally prevailing indigenous practices and the concepts that underlie them makes it possible to more effectively reach the rural poor as the following example illustrates.

The syndrome called runche--found in a high percentage of Nepali children from one to four years of age--was effectively built upon in that country's Lalitpur District Community Health Project. Runche is traditionally interpreted as a spell placed on children after being touched by an unknown pregnant woman; Lalitpur village leaders explained that it afflicts 15 to 50 percent of the district's children. Adults easily recognize a runche child by its symptoms of irritability, whininess, "miserable-appearance," and refusal to eat or cooperate with family activities. The condition often follows episodes of diarrhea, fever, or measles. Traditional treatment includes a series of early morning baths. The project's investigation into the syndrome revealed that all the runche children were underweight and not receiving enough food to ensure adequate growth--thus in a state of early undernutrition. Since runche is a

specific condition recognized by all parents, the project directors decided to regard further professional diagnosis (weighing, measuring, and recording) as an unnecessary expenditure of manpower, time, and materials. The familiarity of project personnel with local cooking methods and foods readily available in every village home permitted them to develop a socially acceptable product that villagers could produce at home both for treatment of a runche child and as a first supplementary food to breast milk for the prevention of runche. The traditional treatment of baths was not discouraged nor was it deemed necessary to "educate" the villagers as to the "true" explanation for the condition. Thus, in this case, understanding an indigenous concept held by community members and then grafting an intervention onto it permitted earlier, faster diagnosis of a common syndrome and treatment before frank marasmus or kwashiorkor could develop.¹

It is important too that discussion of indigenous health practices and their theoretical underpinnings be included in training programs for health professionals of all specialties who will be working with developing-country health care delivery.² The recommendations of an Egyptian consultant to AID are pertinent here. Following a discussion of villagers' preferences for injections ("real medicine") over tablets, he states:

This leads me to recommend that the doctors in rural areas be given an intense course in the cultural patterns of the area they work in. This is not to be based on social work material but on studies which present how the farmers think--their values, attitudes, beliefs, and norms, and especially their attitudes and feelings regarding medicine and medical treatment. In this area of values and norms the doctor can act as an agent of change, but not until he understands the people he is working toward changing. He must know those patterns in which he must work and through which he must introduce change.³

By way of summary, three programmatic questions emerge from the foregoing discussion of collaboration and practices.

1. What are the possibilities for integrating the various categories of indigenous practitioners into the primary care system?
2. If they are not personally integrated, how should they be accommodated?

¹Bomgaars (1976)

²A model for this is presented for Egypt by Nelson and Olesen (1977).

³El-Zein (1973). See also Ademuwagun (1969).

3. How should the indigenous health-related beliefs and practices shared and acted out by the community at large be integrated or accommodated?

These are questions that should be locally investigated and acted upon.

POLICY CONSIDERATIONS

In view of the foregoing, what are policy and program options for health planners, particularly in a donor agency such as AID? The present situation suggests that ways must be found whereby indigenous healing systems can be made supportive rather than treated as obstacles to improved health for the majority. New research and analysis must identify aspects of indigenous practices and beliefs that should be supported. If the U.S. Congressional and World Health Organization goals of improved health for all by the year 2000 are to be achieved, it will be necessary to mobilize all available resources.

Policy for AID

Until recently AID policy statements have contained only fleeting mention of traditional practitioners.¹ This is far from adequate given the much more detailed articulation of other aspects of AID health sector strategy. The present review of existing arguments and evidence regarding traditional health care indicates the desirability of more explicit elaboration.

Taking into consideration (a) AID's Congressionally-mandated goal of cooperation with other governments and other donors to improve the health of the rural and urban poor of the world's developing countries and (b) the present paucity and maldistribution of health resources for achieving these goals, it is recommended that it be AID policy:

- (1) to recognize that indigenous health practitioners are already a major community-based health care resource for rural and low-income urban populations in the developing countries;
- (2) to recognize that in many communities indigenous health practitioners are the only providers of health care and that even where government services exist they are nevertheless frequently bypassed in favor of indigenous practitioners;
- (3) to recognize that even when government services are sought out their impact is frequently compromised by inadequate understanding and regard on the part of

¹AID is developing a new health policy paper, presently in draft, that does go further, however, in discussing training and utilization of indigenous health practitioners.

government health workers for locally-prevailing health and related beliefs and practices;

- (4) to recognize that many indigenous health practitioners are willing to cooperate with government health planners and practitioners for improving the health status within their communities; and, therefore,
- (5) to encourage and support developing country initiatives and efforts in training and utilization of indigenous health practitioners for primary health care;¹ and
- (6) to urge greater understanding of and attention to indigenous health and other locally-prevailing sociocultural practices in the training of all categories of health workers and in the planning and implementation of all health care projects and programs.

The International Policy Context

The above recommendations are consistent with current policy orientations of the international organizations and assemblies in which AID and the countries it assists are members and have participated. The World Health Organization (WHO), since the early 1970s, has taken a lead in encouraging developing countries to mobilize traditional medicine, and especially its manpower component, for primary health care.² Initially the focus was upon traditional birth attendants, for whom UNICEF during the past quarter-century has been supporting training in many countries, including Ghana, Indonesia, Malaysia, Pakistan, Philippines, Sudan, and Thailand.³

¹Preliminary to this it must also be recognized that where use of valuable indigenous health resources is proscribed by legislation or institutional policy, the laws and policies themselves may need to be part of the donor dialogue in negotiating actions to improve the country's health programs. See also the WHO recommendations on legislation in primary health care (World Health Organization 1978b: 76).

²It appears, however, that credit for some of the earliest pioneering work in collaborating with indigenous healers should go to the Christian Medical Commission of the World Council of Churches and its former director, Dr. James McGilvray. It is noteworthy that CMC headquarters is just down the road from WHO in Geneva. Insights into the CMC philosophy and strategy are presented in its publication, Contact. (See, for example, volume 29: "Toward a Broader Understanding of Support and Healing.")

³See the important WHO report, The Traditional Birth Attendant in (cont.)

A Working Group for Promotion and Development of Traditional Medicine was established at WHO headquarters in 1976, and in 1977 a watershed resolution, introduced and sponsored by several developing countries, was passed by the World Health Assembly urging the promotion and development of training and research in traditional medicine (see Annex B).¹ "For far too long," asserted WHO Director-General Halfdan Mahler, "traditional systems of medicine and 'modern' medicine have gone their separate ways in mutual antipathy. Yet are not their goals identical--to improve the health of mankind and thereby the quality of life? Only the blinkered mind would assume that each has nothing to learn from the other."²

Most recently the Alma-Ata International Conference on Primary Health Care has recommended that:

...governments give high priority to the full utilization of human resources by developing teams composed of community health workers, other developmental workers, intermediate personnel, nurses, midwives, physicians, and, where applicable, traditional practitioners and traditional birth attendants.³

It has been said that the significance of both the WHO resolution on traditional medicine and the Alma-Ata Primary Health Care Conference lies in having produced formal commitment from WHO member states--believed to go deeper than only rhetoric--to the principles espoused in the respective resolutions.

Given that AID-supported countries are also WHO member states and given the U.S. Congressional legislation mandating AID to coordinate with other donors and international agencies in health and population, then AID would do well to regard the WHO Programme in Traditional Medicine as an important health policy guide and program resource. The background and premises of the WHO Programme serve as an indication and point of departure as to where governments

(cont.) Maternal and Child Health and Family Planning (Verderese and Turnbull (1975) which remains a--if not the--major reference on training and utilization of traditional birth attendants. Other major sources include Rogers and Solomon (1975), Peng (1974), Mangay-Maglacas (1977), Sargent and Rubel (1976), and Zabarenko (1977).

¹Details are outlined by Dr. R.H. Bannerman, Secretary of the Working Group on Traditional Medicine (Bannerman 1977), and elaborated in WHO regional meeting reports and other WHO documents cited in this paper's bibliography.

²Mahler (1977).

³World Health Organization (1978b:26).

of AID-supported countries stand on this issue. It should be remembered, however, that this varies considerably given the great diversity of indigenous health care systems and not least of all the social and political milieu in which they function.¹

Formal activity in the development and utilization of traditional medicine and its practitioners includes establishment of institutes, upgrading of indigenous practitioners in modern medicine, and training of official system practitioners in traditional medicine.

In at least twenty countries, universities or governments have established institutes of traditional medicine for research and treatment. These include Burma, China, Ethiopia, Ghana, India, Mali, Nepal, Niger, Nigeria, Senegal, the USSR, and Zaire.² Activities undertaken by these institutes are schematically presented on page 30 in the "Résumé of Research Areas in Traditional Medicine."

In India, for example, where ancient medical traditions have been formally institutionalized and legitimized through schools, institutes, and licensing, there is activity in all eight areas presented in the diagram. At the other extreme are countries such as Egypt, which has a physician-centered delivery system and has regulated against indigenous practitioners. Yet even Egypt has ongoing research in pharmacological and therapeutic properties of medicinal plants and certain Ministry of Health officials stress "the importance of traditional medicine" as having "been practiced for over 7,000 years in Egypt."³

A certain proportion of health planners and providers nevertheless remain reluctant to take the indigenous systems very seriously. It may be they do not believe it is worth doing. However, it may also be that they simply do not feel comfortable doing so because they do not know how to do so. In such cases program guidance is especially important.

Program and Project Guidance

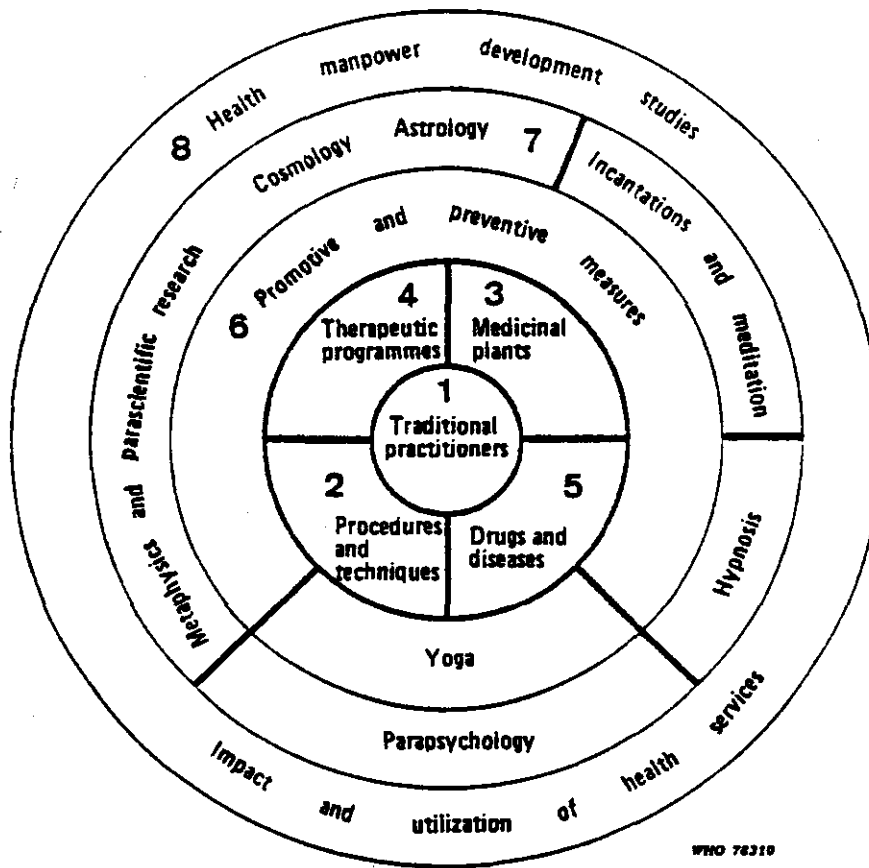
Not only is it feasible for AID to produce guidance on indigenous health care; field personnel from numerous countries have already requested such guidance, both via the Office for

¹By way of example, public policy issues related to traditional health systems in nine African countries are presented in Dunlop (1975).

²World Health Organization (1977b) (A30/A/SR/18). See also WHO's "Bibliography on Evaluation of Traditional Medicines for Safety and Efficacy" (Khan 1976).

³WHO (1977a) (A30/A/SR/17).

Résumé of Research Areas in Traditional Medicine*



1. Research on traditional practitioners of all types;
2. Research on traditional systems, procedures, techniques, technology, and fundamental principles;
3. Medicinal plant research;
4. Evaluation of therapeutic programmes;
5. Research on drugs and diseases;
6. Research on promotive, educational, and preventive measures;
7. Metaphysics and parascientific domains, cosmology and astrology, parapsychology, hypnosis, religious incantations and meditation;
8. Manpower development research; impact and utilization of health services.

*WHO (1978). This figure represents a synthesis of suggestions from WHO member states. It must be viewed with the recognition that agendas for research and utilization of traditional medicine vary from country to country. Nearly all countries, however, have some activity in at least one of the areas.

Development Information and Utilization and directly to geographic and technical offices in Washington.

It is recommended that guidelines be carefully developed and disseminated. Strategies must be conceived and action taken on a country-by-country, and culture-by-culture, basis. Categorical program prescriptions or recommendations about the exact nature of this cooperation, interaction, or accommodation would be unwise. This is not only because of the great diversity of indigenous health systems and practitioners, but also because of the varied political and social systems in which they function. The often excellent and detailed ethnomedical descriptions and analyses that have been produced by anthropologists, medical sociologists, public health specialists, physicians, and others can serve as useful illuminating baseline statements.¹ It is only a few of these, however, that make explicit recommendations for health policy and planning or offer sufficient quantitative data regarding the providers, consumers, and organization of indigenous health care to constitute a basis--in and of themselves--for planning.

Program guidance could be built around the following general conclusions.

1.. Indigenous health practitioners. In developing countries there are two main types of indigenous health practitioners. One is indigenous midwives (traditional birth attendants) who, in addition to delivery functions, often assist in health care and fertility regulation as well. The second is indigenous healers. This includes specialists in physical therapies, such as herbalists, bonesetters, and those who perform first aid and minor surgical operations. It also includes spiritualists such as seers, saints, and other holy people who are sought out for problems often psychological in nature.

2. Indigenous versus international therapies. Considerable evidence shows that where people in a developing country have had access to international or "Western" medicine of reasonably good quality for a generation or so, then they generally place greatest faith in the therapies of that system. This is especially true for treatment of acute, infectious diseases yielding to antibiotics since here international medicine produces demonstrably

¹Probably the best bibliography of these sources for Africa, Latin America, and the Caribbean is the volume by Harrison and Cosminsky. The most thorough bibliography of sources for the Near East (or at least for the seven AID-assisted countries in the region) is to be found in the 1978 Pillsbury monograph. There does not seem to be any similarly comprehensive bibliography of sources for Asia (although they do exist for India and China); this suggests a useful activity for the Asia Bureau to sponsor and make available.

superior results. Where quality care has not been available, then populations still place primary faith in indigenous healers and therapies.

The evidence thus indicates on the one hand the ultimate eventual primacy of international medicine in those areas where services are of reasonably high quality over a lengthy number of years. On the other hand, as indicated above, such a transition to a state of widespread, easily accessible, high quality Western-type health care is providing more lengthy and costly than was previously anticipated.

In either case, where both systems co-exist, resort is usually eclectic. That is, people seek out both Western-type and indigenous practitioners for different problems, for the same problem at different stages in the hierarchy of resort, or even simultaneously for serious problems.

3. Utilization of indigenous practitioners in formally-planned health care systems. This is not an either-or question. Instead it should be seen in the broader context of comprehensive and primary health care programming that emphasizes community participation, self-help, and appropriate technology. In this philosophy of maximal participation, education, and development of all country resources, indigenous practitioners are seen as one category of primary health worker providing services that do not require the more specialized medical knowledge of physicians and other formally-trained professionals.

Whether indigenous practitioners should actually be integrated directly into formal health care services varies from country to country. It depends on the existing health infrastructure, the health status and dispersion of the population, and the type of indigenous practitioner. At this time and for most categories of practitioner, informal collaboration appears easier than formal integration. Attempts should be made to move toward integration of the most effective aspects of the traditional system.

4. Utilization of indigenous midwives (traditional birth attendants). These are usually the most easily incorporated indigenous practitioners. This is evidenced by programs in Latin America, Africa, and Asia where midwives have been upgraded and also trained in family planning and health promotion. WHO and UNICEF have actively investigated and supported this strategy and AID itself currently has some 17 ongoing or planned projects utilizing traditional birth attendants.

5. Utilization of specialists in physical therapies.

Greatest success has been reported with herbalists. Many governments are proud of their indigenous traditions or herbal medicine. Certain Egyptian Ministry of Health officials, for example, have expressed pride in Egypt's "ancient traditional medicine going back several thousands of years." By this they mean specifically the use of herbs. An important part of the WHO Programme in Traditional Medicine encourages member nations to conduct research on the safety and efficacy of traditional herbal remedies.

6. Utilization of spiritualists. This appears more complex than for other kinds of practitioners. However, in countries where traditional healers are formally accepted, experience shows that they may be useful in mental health services.

7. Legislation and licensing. Where legislation has been passed against indigenous practitioners it does not appear to have succeeded in causing them to cease practice so long as there is popular demand for their services, as is the case in Tunisia. Nor does policy that midwives, for example, be upgraded and licensed mean they will all comply. Neither measure seems to bring full compliance. The latter, however, appears to succeed in bringing better care to areas where indigenous practitioners choose to comply and receive training.

8. The WHO Programme in Traditional Medicine as stimulant.

The 1977 WHO resolution to promote traditional medicine encourages all member nations to conduct research on and seek ways of utilizing their indigenous practitioners. The resolution was proposed by certain member nations and has subsequently stimulated others to consider, or reconsider, the training and upgrading of their traditional practitioners. AID personnel should expect that developing-country ministries of health may show new or increased interest in using their indigenous health practitioners as providers of primary care.

9. Training. In most cases formal integration of traditional practitioners entails a certain amount of training and upgrading and, as with any community health worker, supervision and refresher sessions. At the same time, it is desirable that curricula for modern-sector practitioners include explicit familiarization and practical experience with their country's local health care traditions through fieldwork, conferences, and so on.¹

10. Indigenous health care practices. In virtually all cases it is desirable to understand the local etiology and to build interventions upon and around beneficial indigenous practices.

¹A useful conference model might be the Conference on Appropriate Health Care which will bring together in Penang, in March 1979, (cont.)

More fully developed program guidance could be provided to AID missions, even at this time, with only a relatively small input beyond what is presented here.

Recommendations for Sector Studies and Planning

It is recommended that surveys or research into indigenous health care and local health practices be conducted whenever the answer to one of the three following questions is affirmative. This study should be conducted in the host country. Ideally it would be conducted by a team that would include at least one public health specialist and one social scientist, at least one of whom is a country national. Given that family health is a predominantly female domain, it is essential that at least one woman be a member of the research effort. The findings should include specific recommendations for project designs.

1. Is health sector assistance being proposed or given to a country that is utilizing, or considering utilizing, its indigenous practitioners in health or family planning?

a. Obtain an overview of indigenous health care in the given country. This can be done using the outline "Project-Specific Information Needs for Traditional Health Care" (Annex A).

A thorough overview would also include a literature search and an analysis of the relevant works identified. In countries with considerable social science resources (e.g., Egypt, Philippines) this could be done in-country; for others it may necessitate using computerized holdings such as Index Medicus.

b. Support in-depth field research on indigenous practices and practitioners. An expedient starting point might be to use the headings of the country-specific portions of the Near East Bureau's Traditional Health Care in the Near East (Pillsbury, 1978) as the basis of a research design and scope of work. High priority should be given to understanding strategies of resort to the alternative practitioners and therapies.

(cont.) practitioners representing six major healing systems of Malaysia. (The agenda and underlying philosophy are described in a November 1, 1978 proposal for funding from the Consumers Association of Penang to the president of the Ford Foundation.)

2. Is support being proposed for or given to low-cost health systems in a country that is not presently utilizing its indigenous practitioners?

- a. Obtain an overview of the official position on indigenous health practices. This can also be done using the outline "Project-Specific Information Needs for Traditional Health Care."
- b. Support in-depth field research on utilization of existing facilities and strategies of resort. Utilization rates and effectiveness of care provided are the result of complex interaction between the availability of services (including the terms on which they are available), the health status of the population, and the indigenous health beliefs and practices.

There are two types of utilization studies. One takes as its unit of observation the health care facility. This type, since it observes only those who actually visit the facilities, provides only a partial picture of how the health care system is meeting basic health needs.

The second type of study takes as its unit of observation the population for whom care is theoretically being provided. Population-based studies describe strategies of resort to alternative practitioners and therapies and more accurately reveal how effectively health needs are or are not being met by the formal system.¹

It is recommended that population-based utilization studies be conducted in communities identified for AID activity. Emphasis should be on strategies and reasons for resort to the alternative health care providers; rural and urban poor often consult and follow therapies of traditional healers at the same time as or instead of visiting the kind of facility that AID might be supporting or establishing. Knowledge of what motivates this eclectic health-seeking behavior is necessary if AID is to succeed in improving the health of the poor majority.

¹See Benyoussef and Wessen (1974:287) and Nichter (1978). An excellent example of this type of study has been produced by Polly Fortier Harrison for USAID/El Salvador.

3. Are projects being planned and implemented in sectors other than health whose success may be influenced by health-related beliefs and practices?

It is recommended that any field research undertaken on indigenous health care should also identify ways in which traditional health beliefs and practices might hinder success or development efforts in sectors other than health. AID should not presume that it can easily change the traditional practices but should take them into consideration in project design and implementation.

CONCLUSION: AID ACTION NOW

The opening summary and the sections above on evaluation, program and project guidance, and sector studies and planning present what broad conclusions can be reached in the context of this preliminary overview. Actions that could profitably and relatively easily be undertaken at this time include the following:

- * Collection, in AID Washington, of all the scattered and diverse AID-supported studies, conference reports, and project documents dealing with indigenous health care and an evaluative appraisal of this collection.
- * Literature surveys and analyses for AID's Africa, Asia, and Latin America bureaus of traditional health care in the countries of each region with special focus on interaction between the traditional and modern-sector systems in each country. (A partially-annotated region- and country-specific working bibliography on interaction between traditional and modern-sector health care is available as a supplement to this paper and as a preliminary step in this direction. (See Pillsbury and Hunt 1979.)
- * Convening of a workshop of professionals, both AID and non-AID, who have had experience in the utilization of indigenous practitioners and traditional medicine in modern-sector health programs.
- * Provision of more detailed guidance to the field regarding options for utilizing traditional health manpower and building on indigenous health practices.
- * Promotion of sector and evaluation studies on the utilization of alternative health care providers in order to better understand community health systems from the perspective of the low-income populations who are the intended beneficiaries of AID-supported programs.

Many critics of the basic human needs approach in development complain that this approach--including the support of low-cost health delivery systems--is merely a giant welfare program. Supporters insist this is not so and that implicit in the approach is helping people to help themselves in meeting basic needs. Community participation and involvement in health-improvement programs is a related goal that appears with increasing frequency in the plans, speeches,

and documents of international donors and developing-country health officials, but which is considerably more difficult to achieve.¹ The carrying out and eventual findings of such studies as are suggested above could make a valuable contribution in achieving the community involvement that is essential in meeting basic health care needs.

In each case the purpose of the activities outlined above is the same: to improve the design and implementation of health delivery systems--and ultimately the health of the population--through greater knowledge and utilization of community resources and systems that are "already there."

¹Nine case studies and an overview of history, lessons learned, and prospects for the future are presented by the UNICEF-WHO Joint Committee on Health Policy (1977).

Annex A

PROJECT-SPECIFIC INFORMATION NEEDS FOR TRADITIONAL HEALTH CARE*

1. Official Position on Traditional Health Care

- a. What official policies exist?
- b. If such exist, do they support or suppress further development of traditional health care?
- c. Is there licensure, registration, or certification of indigenous health practitioners? If so, what kind?
- d. Is there regulation of the practices of indigenous health practitioners?
- e. If official policies do not exist, what position do high-level officials take on the subject?

2. Traditional Health Care Manpower

- a. What different categories of indigenous health practitioners and advisers exist?
- b. What is the estimated number of persons in each category?
- c. In each category, approximately how many are below 30 years of age? Between 30 and 50? Over 50?
- d. How many are literate?
- e. How many have had formal institutional training?
- f. How many are full-time practitioners? Part-time practitioners?
- g. How were they recruited to their specialization?
- h. How are they compensated for their services?
- i. What position do they take toward government health services and formally-trained practitioners?

3. Modern Technology in Traditional Health Care

- a. Is modern health technology employed by traditional practitioners?
- b. If so, what kind of technology is used?
- c. If not, in which areas of traditional health care would new technology be advantageous?
- d. What kind of health technology would be appropriate?

*Adapted from questionnaire, "Information Needs on Traditional Medicine," developed by the WHO Programme on Traditional Medicine.

4. Traditional Medicines

- a. Does regulation exist governing their use?
- b. What is the approximate proportional use of medicinal plants? Of products of animal origin? Of mineral origin? Of other products?
- c. Is there any pharmacopoeia or systematic list of the above substances?
- d. If not, what are the most common substances in each category?

5. Research and Training in Traditional Health Care

- a. Have traditional health practices or medicines been the subject of research by country nationals? (Example: arthritis, fertility regulation, mental illness, tropical diseases.) Which individuals or institutions have been engaged in this work?
- b. Have attempts been made in the country to train or to integrate indigenous health practitioners into government health services?
- c. If so, what have been the outcomes?

Annex B

WORLD HEALTH ASSEMBLY RESOLUTION:
THE PROMOTION AND DEVELOPMENT OF TRAINING AND RESEARCH IN
TRADITIONAL MEDICINE*

The Thirtieth World Health Assembly,

Noting that primary health care in developing countries has not reached the bulk of populations;

Realizing that in developing countries it is important to make use of available health resources;

Recognizing that traditional systems of medicine in developing countries have a heritage of community acceptance and have played and continue to play an important part in providing health care;

Noting that there are institutions of traditional systems of medicine in some developing countries engaged in providing health care, training, and research;

Noting that WHO has already initiated studies on the use of traditional systems of medicine in its efforts to find alternative approaches to meet the basic health needs of the people in developing countries;

Considering that immediate, practical, and effective measures to utilize traditional systems of medicine are fully necessary and highly desirable;

1. Records with appreciation the efforts of WHO to initiate studies on the use of traditional systems of medicine in conjunction with modern medicine;

2. Urges interested governments to give adequate importance to the utilization of their traditional systems of medicine with appropriate regulations, as suited to their national health systems;

3. Requests the Director-General to assist Member States in organizing educational and research activities and to award fellowships for training in research techniques for studies of health care systems and for investigating the technological procedures related to traditional/indigenous systems of medicine; and

4. Further requests the Director-General and the Regional Directors to give high priority to technical cooperation for these activities and to consider the appropriate financing of these activities.

*World Health Organization (1977b).

Annex C

RECOMMENDATIONS TO THE PAN AMERICAN HEALTH ORGANIZATION REGARDING
INTERACTION BETWEEN INDIGENOUS HEALERS AND FORMAL HEALTH SERVICES

The following recommendations have been extracted from those produced by a special congress sponsored by the Pan American Health Organization in 1977. They constitute useful guidelines for AID as well and support many of the statements in the body of this paper.

1. It is recommended that health policy-makers, planners, and providers relate to curanderos, espiritualistas, parteras, and other types of traditional healers with the assumption these health providers are acting in good faith and making use of all information and concepts about health to which they have access in order to provide badly needed services.
2. It is recommended that health professionals and policy planners assume traditional healers to be open, rather than closed, to new concepts and practices. In view of past attempts to impose legal sanctions on traditional healers, it is not surprising that they are wary of official health agencies; however, there is no evidence to support an assumption that they are inherently hostile to health agency staff or private physicians.
3. It is recommended that health planners assume that services of professionals are provided in a highly competitive consumers' market. Professional health services compete with traditional healers. The request for service by a patient from a health professional clearly demonstrates that the patient has a substantial level of faith in the services he perceives the professional able to give. If faith in a form of treatment is a necessary ingredient to successful healing, such a request is a testament to a belief in the potential efficacy of treatment by a physician as well as by an indigenous healer.
4. It is recommended that health professionals recognize the range of differences in traditional healers both in terms of spheres of competence and types of problem dealt with. Health professionals should be made aware that traditional healers are often used by clients who also utilize physicians or other official health services. Traditional healers often refer clients to the official health care system, but their contributions and role in the illness referral system may be unknown to official health providers.

5. Biological and social definitions of disease often differ. It has been suggested that traditional healers may be particularly competent in treating social aspects of illness and physicians particularly competent in treating the biological aspects. Although it would seem advantageous to combine the competencies of both healer and physician, caution must be exercised in designing integrative health care programs so that healers are not disenfranchised (nor given lower status) by the official health system. It is recommended that donors support research to develop testable strategies of cooperation between healers and official health systems.
6. It has become clear that for some health problems the efficacy of different forms of treatment, whether provided by the indigenous healer as a solo practitioner or in coordination with the official health system, is unknown. It is recommended that donors support empirical studies and training programs that would assist in permitting further recommendations to health care providers as to the effective methods for cooperating with healers and utilizing their competencies.

Recommendations for training

7. It is recommended that donors support holistic training of health professionals. This has been an emphasis in Western medicine, but with increasing specialization it is often difficult to train medical practitioners in the holistic traditions that have been an ideal of Western medicine. Donors are encouraged to be part of the return to this ideal. Field research shows that traditional healers tend to deal with patients in a more holistic sense. Patients themselves expect to be treated in terms of both their social aspects of life and their biological difficulties. If health professionals are trained to be more holistic, they will also be able to treat patients in a way that is more congruent with the patient's notions of self.
8. Health professionals are cautioned to beware of the "fallacy of empty vessel," in other words, of treating patients as if the patients had no experience or explanatory system for their conditions. Instead it should be assumed that patients are responding to symptoms by means of a set of logical principles which reasonably explain to them the nature of their symptoms and the etiology and course of the illness.

9. It is recommended that professional staffs be trained to understand that when compliance with a recommended regimen proves inadequate, reasons for that lack of compliance are rational and may be understood by a professional.
10. It is recommended that donors support the training of host country professional anthropologists and other social scientists including training in medical anthropology and public health. This could be done through a university where there are both a school of public health and an anthropology department.
11. It is recommended that donors support in-service training programs for health professionals that incorporate skilled, articulate healers (as has been done at Universidad Nacional Autonoma in Mexico). Although it is important to allow healers their own autonomy, including them in the training of health professionals should facilitate more general recommendations.
12. It is recommended that health professionals be trained with an emphasis on rural health problems and the problems of under-served populations.
13. It is recommended that donors recognize that medical training or models based on U.S. medical training may not be appropriate for developing countries, even at higher levels of the professional ladder, in that they are premised on different cultural values and are themselves in a state of change. It is extremely important that we not take ideas from U.S. medical education, which may be undergoing change, and continue to export them to developing country health professionals. An example is teaching traditional midwives to use the lithotomy position, which is increasingly questioned in U.S. medical training.
14. It is recommended that donors support training programs for a variety of traditional healers keeping in mind that they must be allowed to maintain their own authority and position within their communities rather than being disenfranchised by incorporation into the official health system.

Recommendations for research support

15. It is recommended that donors support research to evaluate the relative efficacy of treatments for specific illness utilized by different categories of traditional healers.

16. It is also suggested that donors support empirical research to help understand to what degree the health behavior of clients, healers, and providers is different in rural areas as opposed to urban areas. It would be important to understand the effect of migration to the city on changing health attitudes and behavior.
17. It has become clear that there are few community studies in which social class is a variable rather than ethnicity. Most studies of developing country populations are based on the health behavior of the poorest groups. More needs to be known about the extent to which this is a class phenomenon rather than ethnic phenomenon.
18. It is also recommended that prior to, or as a subset of initiating empirical research, donors commission the collection of existing information on the efficacy of different forms of treatment and on the incorporation of traditional healers.

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